



DEFERRED  
COMPENSATION  
PROGRAM

## PARTICIPATION AGREEMENT

STATE OF WASHINGTON  
DEPARTMENT OF RETIREMENT SYSTEMS

Mail To:  
PO Box 40931  
Olympia, Washington 98504-0931  
Toll Free: 1-888-327-5596  
TDD: 1-877-847-6041

Social Security Number		Employer Name						
Employee Name Last		First		Middle Initial		Day Phone ( )		
Street Address						Evening Phone ( )		
City		State	Zip + 4		Birthdate MM DD YYYY		Gender <input type="checkbox"/> M <input type="checkbox"/> F	

### Deferral Information

I authorize my employer to defer \$ \_\_\_\_\_ OR \_\_\_\_\_% from my pay monthly (see instructions).

### Investment Allocations

(Use whole percentages only)

(10) Savings Pool	_____ %	(40) Fidelity Equity Income	_____ %
(25) WA State Bond Fund	_____ %	(50) US Stock Market Index	_____ %
(70) WA State Short-Horizon	_____ %	(60) Fidelity Independence	_____ %
(71) WA State Mid-Horizon	_____ %	(75) Fidelity Growth Company	_____ %
(72) WA State Long-Horizon	_____ %	(77) Fidelity Overseas	_____ %
(30) CSIF Balanced Portfolio	_____ %	TOTAL must equal <b>100%</b>	

### Beneficiary Designation

I understand if I select more than one Primary Beneficiary or more than one Contingent Beneficiary, the total percentage(s) (whole numbers only) for each category must add up to 100%. I wish to designate the following beneficiary(ies) in accordance with the provisions of the Plan:

Primary <input checked="" type="checkbox"/>					_____ %
	Social Security Number	Name: Last, First, MI		Relationship	Date of Birth
<input type="checkbox"/> <input type="checkbox"/> Primary Contingent					_____ %
	Social Security Number	Name: Last, First, MI		Relationship	Date of Birth
<input type="checkbox"/> <input type="checkbox"/> Primary Contingent					_____ %
	Social Security Number	Name: Last, First, MI		Relationship	Date of Birth

<input type="checkbox"/> <input type="checkbox"/> Primary Contingent					_____ %
	Social Security Number	Name: Last, First, MI		Relationship	Date of Birth
<input type="checkbox"/> <input type="checkbox"/> Primary Contingent					_____ %
	Social Security Number	Name: Last, First, MI		Relationship	Date of Birth

**Important: Read before signing.** I authorize my employer to deduct the amount or percentage set forth above each month and transmit to the Deferred Compensation Program. I further authorize my employer to deduct any deferral changes I request through the Deferred Compensation Program in the future. This agreement will continue until further notification by me, as set forth in the plan. I understand a plan expense will be applied to my account value. I acknowledge I have read and understand all sections of the "Memo of Understanding" of this agreement.

**X**

DRS D 112 (10/01) Employee Signature

Date

Send Original to DCP and make a copy for your files